2024

ID#:_____

PEAK CHIROPRACTIC

TAKE YOUR HEALTH TO THE PEAK!

Date: _____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: ____/____/_____ Age: _____ Gender: M F Preferred Name: _____

Cell Phone: _____ Alternate Phone: _____ (Circle Preferred)

Email: _____

Marital Status (circle one): Single Married Divorced Widowed Separated

Race/Ethnicity (circle one): White Black/African American Hispanic or Latino Other

Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Doctor: _____ Phone: _____

How did you hear about us? _____

_____

_____

Adjusting Method (Circle Preference): Tool/Activator Manual/By-Hand Don't Know N/A

Communication:

- ☐ Email reminder 2 days before scheduled appointment
- ☐ Text message (SMS) reminder 24 hours before appointment

Promotions:

- ☐ Yes, I would like to receive news and special promotions by email

Patient signature: _____ Date: _____

What brings you in today? _____

Can you think of any that may have caused this? _____

Date complaint began: ____/____/____ **Is it improving:** Yes No Constant Comes and Goes

Have you had this or a similar complaint in the past? Please describe: _____

_____

What does your complaint feel like (check all that apply):

☐ Dull	☐ Shooting	☐ Tight	☐ Burning
☐ Ache	☐ Sore	☐ Numbness	☐ Cramping
☐ Sharp	☐ Pulling	☐ Tingling	☐ Swollen
☐ Stabbing	☐ Stiffness	☐ P/Ns (like it is asleep)	☐ Other
☐ Throbbing	☐ Annoying		

Please rate your discomfort on the scale below where 10 is the worst pain you can imagine:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Does the pain travel (Down either arm or leg, up or down the spine, into a headache, etc) Please describe:

_____

Has anything made your discomfort better?

☐ Ice	☐ Standing	☐ OTC Medication
☐ Heat	☐ Sitting	☐ Prescription Medication
☐ Rest	☐ General Movement	☐ Other
☐ Stretching	☐ Walking	

Has anything made your discomfort worse?

☐ Ice	☐ Standing	☐ OTC Medication
☐ Heat	☐ Sitting	☐ Prescription Medication
☐ Rest	☐ General Movement	☐ Other
☐ Stretching	☐ Walking	

When do you experience the most discomfort?

☐ Morning	☐ Afternoon	☐ During activities
☐ As the day progresses	☐ Evening	☐ When sleeping

Did you seek any treatment prior to today? Please describe: _____

_____

Have you been adjusted before? Y N **Previous doctor and most recent visit:** _____

Are there any other symptoms that you think may be associated with this complaint? If yes, please describe:

_____

How committed are you to correcting this issue? _____

Please describe if and how your current symptoms impact the following:

- ☐ Sleeping
- ☐ Working
- ☐ Exercising
- ☐ Relationships
- ☐ Self Care
- ☐ Energy
- ☐ Attitude
- ☐ Patience
- ☐ Other

Personal Medical History (Please list any details):

- ☐ Past Accidents/Injuries/Traumas: _____
- ☐ Previous hospitalizations and dates: _____
- ☐ Last physical/doctor visit: _____
- ☐ List any previous surgeries and dates: _____
- ☐ Illnesses: _____
- ☐ Allergies: _____
- ☐ Medications (list and specify condition/usage): _____
- ☐ Supplements (include dosage and frequency): _____
- ☐ Do you smoke/dip/vape/use tobacco (include quantity, frequency, and duration): _____
- ☐ Do you drink (describe frequency and amount): _____
- ☐ Do you use any recreational drugs (please describe): _____
- ☐ How much water do you drink per day: _____
- ☐ How much do you exercise (Daily, weekly, briefly describe): _____
- ☐ Other _____

Additional Personal Medical History (current and past conditions):

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Arthritis
- ☐ Allergies/Asthma
- ☐ Back Pain
- ☐ Cardiovascular issues
- ☐ Multiple Sclerosis or other neurological issues
- ☐ Neck Pain
- ☐ Obesity
- ☐ Osteoporosis/Osteopenia
- ☐ Reproductive Issues
- ☐ Lymphatic Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Immune Issues
- ☐ Ringing in ears (Tinnitus)
- ☐ Hepatitis/Liver disease
- ☐ Scoliosis
- ☐ Shoulder issues
- ☐ Stroke
- ☐ Heart Disease
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Gastrointestinal issues
- ☐ Elbow/Wrist/Hand issues
- ☐ Hip/Knee/Ankle issues
- ☐ Thyroid issues
- ☐ TMJ issues
- ☐ Urinary issues
- ☐ Unexplained weight loss or gain
- ☐ Other

Direct Family (Parents, Siblings, and Children) Medical History, please list family member and age of onset:

- ☐ Hospitalizations and dates: _____
- ☐ Illnesses: _____
- ☐ Allergies: _____
- ☐ Heart Disease: _____
- ☐ Stroke: _____
- ☐ Cancer: _____
- ☐ Connective Tissue Disease: _____
- ☐ Diabetes: _____
- ☐ Alcoholism: _____
- ☐ Obesity: _____
- ☐ Other: _____

Are you currently pregnant or trying to become pregnant? Y N **Expected due date:** _____

Is there anything else that the doctor should know about you? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Accuracy of Information

My signature below certifies that the above medical information is correct to my knowledge.

Patient Name: _____ Patient Signature: _____ Date: _____

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INFORMED CONSENT TO EXTRACORPOREAL SHOCKWAVE THERAPY TREATMENT

The nature of Extracorporeal Shockwave Therapy, also known as SoftWave Tissue Regeneration Technology treatment: The doctor will apply ultrasound gel to the area of treatment and use the applicator of the SoftWave machine on the area of skin. The SoftWave machine will generate audible sound, soundwaves, that will be directed by and through the applicator. These acoustic shock waves will enter the body to create a physiological response primarily for pain relief and may offer an improvement of function.

Suitability for SoftWave Tissue Regeneration Technologies:

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

- Have you been injected with cortisone within the last 30 days? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer / tumor? Yes / No
- Do you have a skin infection? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

Possible Risks:

A. Pain and soreness. This is temporary and resolves after a few days.
B. The FDA has labeled this a "Non-Significant Risk" therapy

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

I have read the explanation above of SoftWave TRT. I understand that I will have the opportunity to have any and all questions answered to my satisfaction prior to treatment. I understand and agree that no guarantees have or will be made regarding this therapy. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

_____ _____ _____

Printed Name Signature Date

Peak Chiropractic
136 Furman Rd Ste 1, Boone, NC 28607
828-264-4521
boonechiropractor@gmail.com

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Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as described in the Consent for Use or Disclosure of Health Information. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

List below the names and relationship of any people to whom you authorize Peak Chiropractic to release Private Health Information:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian, or Patient Legal Representative Name (please print)

_____

Signature

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION:

There are several circumstances in which we may use or disclose your healthcare information. They are listed below:

- We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of your services.

- We may have to disclose your health information to another healthcare provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may need to use your health information within our practice for quality purposes or other operational purposes.

We reserve the right to change our privacy practices as described in this notice. If we make a change in our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. If we agree with your restrictions, the restriction is binding with us.

You may revoke your consent to us at any time. Your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read the consent policy and agree to its terms. I am acknowledging I have received a copy of this notice. I also acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them, and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

Name: _____ Signature: _____Date: _____

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PEAK CHIROPRACTIC FINANCIAL POLICY

Please read the following information carefully and please ask us if you have any questions.

All patients are responsible for payment in full for any and all services provided to them at the time of service. The chiropractor may make the decision to provide additional services or therapies at the time of your visit, in addition to the adjustment, as he/she deems necessary. If you have any questions regarding charges or costs regarding services, you are responsible for asking prior to services being rendered.

Medicare Policies:

We are a non-participating provider with Medicare. This means that you are responsible for full payment of all services rendered at the time of service. We will bill Medicare accordingly and you will receive a reimbursement from Medicare directly. Medicare covers "medically necessary" adjustments to the spine only.

Medicare covers up to 80% of medically necessary adjustment cost, but Medicare reimbursements vary depending on individual policies.

Other Insurance Policies:

We do not accept, nor bill, any other insurance policies/carriers. We are happy to note that many insurance policies do cover chiropractic services that are "medically necessary." We will provide you with a super bill, upon your request, that outlines diagnosis and treatment codes for you to submit on your own.

We do not take responsibility or provide a guarantee that your individual policy will or does cover chiropractic treatment.

FINANCIAL RESPONSIBILITY STATEMENT

You acknowledge that you have read this financial policy and agree that you are responsible for full payment of all services at the time of service.

If you have questions regarding any services that the chiropractor recommends to be performed during your appointment, you are responsible for asking prior to services being rendered.

Name:_____ Signature:_____ Date:_____

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PEAK CHIROPRACTIC CANCELLATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor's day that could have been filled by another patient. As such, our cancellation policy is as follows:

1. Cancellations made more than 24 hours before your appointment will have no fee.

2. Cancellations within 24 hours of your appointment are subject to a 50% fee of your scheduled appointment.

3. Missed appointments, no show visits, and visits cancelled within 30 minutes of your scheduled time are subject to a fee equal to the full amount of your missed appointment.

Please note that appropriate notice of a cancellation is to either call the office at 828-264-4521 or to email the office at boonechiropractor@gmail.com. You must provide us with your name and the date and time of your appointment. Voicemails are also an acceptable form of notice.

Calling the office number without speaking with someone or without leaving a voicemail with the required information does not satisfy appropriate notice in regards to this policy.

Emergencies happen, and we understand. We will work with you in an extenuating circumstance and we reserve the right to waive this policy on a case-by-case basis.

ANY FEES DUE TO THE CANCELLATION POLICY MUST BE PAID PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT. RESCHEDULING A VISIT IS SUBJECT TO THIS POLICY. IF YOU HAVE A SAVED CARD ON FILE, IT WILL BE UTILIZED TO UPHOLD THIS CANCELLATION POLICY. IF YOU HAVE A PRE-PAID PACKAGE, YOUR ACCOUNT CREDIT WILL BE UTILIZED TO UPHOLD THIS CANCELLATION POLICY AS DESCRIBED ABOVE.

Name: _____ Signature: _____Date: _____

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